IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER– Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
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March 30, 2007

Michelle Anderson, Administrator
Rosetta Assisted Living-Pendlebury
1970 East 17th Street #103
Idaho Falls, ID 83404

License #: RC-692

Dear Ms. Anderson:

On January 12, 2007, a state licensure survey was conducted at Rosetta Assisted Living - Pendlebury. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Karen McDannel, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

Karen McDannel, RN

KAREN MCDANNEL, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

KM/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program

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January 23, 2007

CERTIFIED MAIL #: 7003 0500 0003 1967 0551

Michelle Anderson, Administrator
1970 East 17th Street #103
Idaho Falls, ID 83404

Dear Ms. Anderson:

Based on the state licensure survey conducted by our staff at Rosetta Assisted Living - Pendlebury on **January 12, 2007,** we have determined that the facility failed to retain a licenses administrator responsible for the day-to-day operations of a single facility for a period more than 30 days. The facility also failed to protect residents from inadequate care. Based on observation, interview, and record review it was determined the facility failed to protect resident rights by not provideing a safe and sanitary environment and failed to treat residents with dignity and respect for 4 of 4 sampled residents (#1, #2, #3, #4). This failure had the potential to affect 100% of the residents in the facility. Additionally, the facility failed to develop an NSA to describe how the residents needs would be met for 1 of 4 sampled residents (#3) and failed to implement an NSA for 1 of 4 sampled residents (#1). The facility also failed to develop an NSA to identify and describe resident behavior management needs for 2 of 4 sampled residents (#3, #4). Additionally, the facility failed to provide supervision for 1 of 4 sampled residents (#2).

These core issue deficiency substantially limits the capacity of Rosetta Assisted Living - Pendlebury to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **February 26, 2007.** **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the

deficient practice does not recur?

- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **February 5, 2007,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**February 5, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **February 5, 2007,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **February 12, 2007**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Rosetta Assisted Living - Pendlebury.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/slc

Enclosure

c: Debra Ransom, R.N., R.H.I.T., Chief, Bureau of Facility Standards
Paula Gilbert, RN, Nurse Reviewer, Regional Medicaid Services, Region VI - DHW

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R692	A. BUILDING _____ B. WING _____	01/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSETTA ASSISTED LIVING - PENDLEBURY	875 S PENDLEBURY BLACKFOOT, ID 83221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiency was cited during the standard survey conducted at your residential care/assisted living facility. The surveyors conducting your survey were: Karen McDannel, RN Team Coordinator Health Facility Surveyor Polly Watt-Geier, MSW Health Facility Surveyor Donna Henscheid, LSW Health Facility SurveyorSurvey Definitions: BMP = Behavior Management Plan NSA = Negotiated Service Agreement UAI = Uniform Assessment Instrument	R 000		
R 004	16.03.22.215.03 Licensed Administrator Requirement - 30 Days The facility may not operate for more than thirty (30) days without a licensed administrator. This Rule is not met as evidenced by: Based on interview, observation and record review it was determined the facility failed to retain a licensed administrator responsible for the day-to-day operations of a single facility for a period more than 30 days. During the preparation for the standard survey conducted on 8/24/06, a review of the facility	R 004		

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R 004	Continued From page 1 correspondence revealed the administrator was the licensed administrator for two licensed buildings. Additionally, there was no documented evidence the facility had been granted an administrator variance to allow the current licensed administrator to oversee two licensed buildings. On 1/10/07 at 9:43 a.m., the administrator's license was observed hanging on the office wall. On 11/12/07 at 8:24 a.m., the administrator stated she had been the current administrator over two licensed buildings since June 2006. The facility had operated for more than 30 days without a single licensed administrator responsible for the day-to-day operations.	R 004		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to protect resident rights by not providing a safe and sanitary environment and failed to treat residents with dignity and respect for 4 of 4 sampled residents (Resident #1, #2, #3, #4). This failure had the potential to affect 100% of the residents in the facility. The facility failed to develop an NSA to describe how the residents needs would be met for 1 of 4 sampled residents (Resident #3) and failed to implement an NSA for 1 of 4 sampled residents (Resident #1). The facility also	R 008		

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R 008	Continued From page 2 failed to develop an NSA to identify and describe residents behavior management needs for 2 of 4 sampled residents (Residents #3 and #4). Additionally, the facility failed to provide supervision for 1 of 4 sampled residents (Resident #2). The findings include: I. Resident Rights A. Each resident has the right to a safe and sanitary environment. 1. Review of the facility's "Infection Control" policy on 1/11/07 documented, "it is our responsibility and goal to keep the environment free from disease causing pathogens". The facility's "Cleaning" policy un-dated, documented it was the facility's "goal is to maintain a clean, sanitary, and orderly environment. Cleaning service will be done on a routine basis depending on the individual facility needs." Review of the document entitled "Deep Cleaning Tasks Defined" on 1/11/07 revealed detailed instructions of how caregivers would deep clean the facility. It documented cleaning would be done in the following areas: *Residents' Rooms - The light switch plates would be clean, the doorknobs and handles would be disinfected by an "appropriate disinfectant" and the doors would be washed. *Kitchen and/or Dining Room - The cupboards shelves, interior and exterior doors and handles would be cleaned using an "appropriate cleaning solution".	R 008		

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R 008	Continued From page 3 *Laundry Room - The handles and/or doorknobs would be disinfected with an "appropriate" cleaning solution. *Hallways - The handles and/or doorknobs would be disinfected with an "appropriate" cleaning solution. *TV Room/Living Room/Main Living Area - The light fixture would be cleaned inside and out and the floors would be cleaned and vacuumed "per carpet cleaning procedure". *Main Bathroom and/or Residents' Bathrooms - paper towels, soap, and toilet paper would be restocked as needed and the doorknobs and/or handles would be disinfected. Review of the facilities December 2006 and January 2007 "Cleaning/Duties Schedule" revealed the facility had not spot cleaned the carpets every Wednesday or as needed from 12/30/06 to 1/9/07. It also documented the facility had not washed marks and smudges off of the walls and doors every Thursday from 12/24/06 to 1/9/07. On 1/10/07 at 8:45 a.m., the facility was observed to have a strong smell of urine. The living room contained two coffee colored chairs that were observed to have large stains on the cushion and back of the chairs. Additionally, the two chairs were observed to have a strong urine odor. A floral couch was observed to have a strong urine odor. A red chair was observed to be covered with crumbs and/or debris. The brown chair on the right of the fireplace was stained and had strong urine odor. The carpet was stained and generally worn in the living room and hallways. The white ceiling fan had thick dust build up.	R 008		

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R 008	Continued From page 4 On 1/10/07 between 8:53 a.m. and 9:48 a.m., a tour of the facility hallways and resident rooms were observed in the following conditions: *The door handles observed in the hallways, residents' bathrooms and residents' rooms had crusty residue. *Resident room #4 was observed to have a glider chair with a cushion missing, the cream colored spring liner was observed to have two brown spots that were 4"x 1/4" and 5" x 2". *Resident room #5 was observed to have a strong urine odor. A large wet spot was observed on the bedspread. There was an eight inch brown spot on the carpet left to the left of the bathroom door, the carpet had a large stain beside the bed, and large black marks in front of the bathroom door. A brown smudge was observed on the bathroom door frame. The arms of a blue chair were caked with debris and the seat contained brown stains. A second blue chair had four brown stains on the cushion. *Resident room #8 was observed to have small brown smudges on the toilet riser handle bars. *Resident room #10 was observed to be out of toilet paper. *Two public bathrooms were observed to be out of paper towels. On 1/10/07 between 8:53 a.m. and 9:48 a.m., the kitchen was observed to have a clear sticky oily film on the outside doors and on the inside shelves of cabinets near the cooking area. The pull out cabinet drawer, where the toaster was	R 008		

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R 008	Continued From page 5 stored, was full of crumbs. The can opener was sticky with build up of debris and the pantry had a large amount of onion skins on the carpet flooring. On 1/10/07 at 8:56 a.m., a pile of dirty clothing was observed on the floor of the laundry room. On 1/10/07 at 9:18 a.m., the house manager confirmed the furniture and carpeting were worn and needed to be replaced. She also confirmed that the carpet in resident room #5 needed to be replaced. Additionally, the house manager confirmed the facility was not kept in a clean condition. 2. Review of the facility's "Infection Control" policy on 1/11/07 documented, "gloves will be worn by anyone touching blood, body fluids, mucous membranes, or non-intact skin. Gloves will also be used when handling items and surfaces soiled with blood, body fluids, and for performing any vascular access procedure. Gloves will be changed after contact with each resident. Good handwashing is to be used." On 1/10/07 at 9:05 a.m., a caregiver was observed to use gloves when assisting a resident with blowing his nose. After assisting the resident, she was observed not changing her gloves or washing her hands before walking into another resident's room to assist with cares. On 1/10/07 at 9:23 a.m., a caregiver was observed in the kitchen wearing gloves and an apron. She was observed leaving the kitchen with the same gloves and apron to assist a resident with cares. She then returned to the kitchen wearing the apron and gloves. Additionally, the caregiver left a second time wearing the apron	R 008		

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R 008	Continued From page 6 and gloves to assist another resident with cares. She then returned to the kitchen wearing the same gloves and apron. She was not observed changing her apron or gloves and she did not wash her hands in between working in the kitchen and providing residents with cares. On 1/10/07 at 12:10 p.m., a caregiver was observed coming out of a resident's room and going into the kitchen. She then served residents their meals without washing her hands. On 1/10/07 at 10:03 a.m., the house manager confirmed proper glove use and handwashing was not being done at the facility by caregivers. B. Each resident has the right to be treated with dignity and respect. 1. On 1/10/07 at 8:45 a.m., the residents' were observed wearing clothing that was dirty and/or stained, and not properly groomed. On 1/10/07 at 8:48 a.m., Resident #2 was observed wearing stained and dirty pants, jacket and shoes. He was also observed to have disheveled and greasy hair. He also was observed with a thick layer of brownish orange build-up on his fingers. On 1/10/07 at 9:11 a.m., Resident #1 was observed to have long dirty nails and was wearing stained clothing. On 1/10/07 at 9:20 a.m., Resident #4 was observed to be wearing a pink housecoat with light brown stains down the front. On 1/10/07 at 11:45 a.m., Resident #3 was observed sitting at the dining room table wearing	R 008		

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R 008	Continued From page 7 soiled clothing, his teeth had a thick build up of debris, and his nose was draining thick yellow-green mucus. On 1/10/07, 1/11/07, and 1/12/07, Resident #2 was observed wearing the same stained and dirty pants, for a total of 3 days in a row. On 1/11/07 at 11:43 a.m., the administrator confirmed with a nod, the residents' personal hygiene needs were not met. II. NSA's A. Development of NSA Resident #3 was admitted on 6/13/06 with diagnoses which included schizophrenia, paranoid type; dementia; and tardive dyskinesia. The resident's record contained a UAI dated 6/11/06, which documented the resident had extensively impaired cognition, required moderate assistance with eating meals, required extensive assistance with toileting, personal hygiene and/or oral hygiene and dressing. The NSA dated 6/13/06, documented the resident required moderate assistance and supervision oversight for eating meals to ensure adequate nutrition, extensive assistance to manage bowel and bladder incontinence and total assistance in personal grooming needs. Under the dressing/grooming comment section there was a handwritten note that documented the resident was "Resistive to oral cares..." The Progress Notes were reviewed and documented the following:	R 008		

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R 008	Continued From page 8 On 12/19/06, "...resident has a dental appointment in next couple of weeks." On 12/28/06, "...going to the dentist January 3, 2007 to have his teeth pulled..." A Nursing Assessment dated 12/22/06, documented the following assessment under the Nutrition Section: *Nutrition: The "No problem" box was checked. *Hydration: The problem box was blank indicating no problem. *Chewing difficulties: The box was blank indicating no problem. The facility's December 2006 bowel and bladder tracking sheet was reviewed. It documented the resident did not have a bowel movement from 12/20/06 through 12/30/06, indicating the resident had not had a bowel movement for 11 days. On 1/10/07 at 12:15 p.m., the resident was observed holding a red plastic cup containing a beverage. He held the cup in both hands while he sat at the dining room table. The resident was unable to tip his head back far enough to take a drink from the cup or bring the cup to his mouth to take a drink. After 15 minutes, the surveyor asked staff to bring the resident a straw. Once provided the straw the resident was able to drink the beverage. On 1/10/07 at 12:30 p.m., the resident's lunch arrived to the dining room table. The meal provided was a chicken casserole, steamed mixed vegetables, and a slice of bread with butter. The resident was observed struggling to get the food on his utensil, most of it falling off before reaching his mouth. During the meal the	R 008		

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R 008	Continued From page 9 resident became agitated and attempted to leave the dining area. Staff re-directed the resident back to the table to finish his meal. Observations on 1/10/07 between 2:50 p.m. and 5:00 p.m., revealed staff did not offer or provide fluids to Resident #3. On 1/11/07 at 9:45 a.m., the resident was not observed being offered or provided fluids. On 1/11/07 at 2:00 p.m., the resident was not observed being offered or provided fluids. On 1/11/07 at 3:40 p.m., staff was observed to offer the resident a cookie, no beverage was offered during this time. On 1/10/07 at 2:30 p.m., two caregivers were interviewed regarding the resident's inability to drink from a cup without the use of a straw. The caregivers confirmed the resident did need a straw to drink from a cup. They stated fluids were offered to the resident every hour to ensure the resident stayed hydrated. When asked about the resident's ability to eat, caregivers confirmed the resident does experience difficulty at times when using utensils and eating his food. On 1/11/07 at 9:45 a.m., a caregiver stated the bowel and bladder monitor tracking record for the resident was not accurate. She was unable to provide any further documentation that would verify the resident had a bowel movement during the 11 days in December. The NSA did not include specific interventions related to the resident's dining needs. For example, there was no direction given to staff to include the use of a straw when providing fluids to	R 008		

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R 008	Continued From page 10 the resident or how often to offer the resident a beverage. There was no direction to staff to increase fluids or provide interventions for the resident who had a history of constipation. There was no direction to staff regarding the resident's current dental issues or the impact it would have on his eating or nutrition. B. Implementation of NSA Review of Resident #1's record on 1/10/07 revealed the resident was admitted on 6/4/04 with diagnoses that included dementia. The resident's record contained an NSA dated 10/26/06 which documented the resident required total assistance with bathing. It also documented the resident was to receive showers 2 times a week. Additionally, it documented if the resident refused bathing, staff was to ask again on the same shift, change caregiver, or ask again on the next shift. Review of the facility's October 2006 "Resident Shower Schedule" documented the following, which indicated the resident did not receive a shower for 7 days: On 10/3/06 the resident received a shower On 10/6/06 the resident refused to have a shower On 10/10/06 the resident received a shower Review of the facility's October 2006 and November 2006 "Resident Shower Schedule" documented the following, which indicated the resident did not receive a shower for 16 days: On 10/24/06 the resident received a shower On 10/27/06 the resident refused a shower On 11/3/06 the resident refused a shower	R 008		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 11 On 11/10/06 the resident received a shower Review of the facility's January 2007 "Resident Shower Schedule" on 1/11/2007 revealed the resident had not received a shower since 1/1/07. On 1/11/07 at 11:18 a.m., the administrator confirmed the resident had not been showered twice a week. The facility did not implement Resident #1's NSA to ensure her personal hygiene needs were being met. C. Behavior Management 1. Resident #3's UAI dated 6/11/06, documented the resident had schizoaffective disorder, dementia and was totally confused. The cognitive/behavior assessment documented the resident wandered and could be demanding and uncooperative. Resident entered others rooms and could be verbally abusive. The assessment further documented the resident had antisocial behavior, displayed disruptive/socially inappropriate behaviors, anxiety, agitation and could have inappropriate sexual behaviors. The NSA dated 6/13/06, documented the resident had schizophrenia, paranoid type, dementia, and was nonverbal. There was no documented evidence in the NSA of a BMP to direct staff for interventions to reduce or eliminate aggressive and challenging behaviors displayed by the resident. Review of the resident's history and physical dated 6/19/06, documented the following under Social Relationships:	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R692	A. BUILDING _____ B. WING _____	01/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSETTA ASSISTED LIVING - PENDLEBURY	875 S PENDLEBURY BLACKFOOT, ID 83221

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R 008	Continued From page 12 "Resident is unable to verbally communicate and has a substantial history of combative and emotional problems. Resident needs to be monitored closely to keep him from abusing others around him." Review of the facility's "Behavior Observation/Intervention" form dated 8/13/06, documented the resident ejaculated in public at the dinner table and living area. It documented alternative interventions which included: give resident a shower, take him for a walk or provide him snacks. The following Progress Notes were reviewed and documented the following: *9/26/06, [time not entered] "... resident is masturbating in kitchen, living room and bedroom..." *10/7/06, [un-timed] "...wandering in others rooms, gets combative when staff redirects..." *11/20/06, [un-timed] "...resident has been throwing himself on the ground today, also refusing to be changed." *11/27/06, [un-timed] "(resident's name) has been refusing his pills and keeps running from staff..." *12/2/06 [un-timed] "(resident's name) seems very agitated today..." Review of the facility's Incident Investigation report dated 12/12/06, documented Resident #3 slapped a resident for sitting too close to him on the sofa. Staff documented they put both residents on alert charting for "attitude".	R 008		

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	13R692	A. BUILDING _____ B. WING _____	01/12/2007

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R 008	Continued From page 13 On 1/10/07 at 11:45 a.m. a caregiver was interviewed regarding how staff were to manage Resident #3's behaviors. She stated, "we try to re-direct the resident, by providing him a shower or offering him a banana." On 1/11/07 at 5:00 p.m., the administrator confirmed the facility had not developed or implemented a BMP. On 1/11/07 at 5:05 p.m., the house manager confirmed the facility had not developed or implemented a BMP. 2. Resident #4 was admitted to the facility on 11/18/06, with diagnoses which included Alzheimer's dementia, delusional disorder and depression. The NSA dated 11/20/06, documented the resident was slightly confused and had behaviors. There was no documented evidence in the NSA of a BMP to direct staff for interventions to reduce or eliminate aggressive and challenging behaviors displayed by the resident. The Progress Notes were reviewed and documented the following: *12/11/06, "Resident complaining about residents and staff..." *12/14/06, "Resident has been rude to staff members, believes it is their fault..." *12/18/06, "Resident clogged her sink with a plant..." *12/19/06, "Resident is showing some rude behaviors toward staff. Will keep an eye on her." *1/4/07 at 6:00 p.m., "Resident yelled profanities at the aides..." *1/8/07 at 10:00 a.m., "...Maybe talk to	R 008		

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R 008	Continued From page 14 [unreadable] and have her meds switched due to her behavior." On 1/10/07 at 12:45 p.m., Resident #4 was observed sitting at the dining room table for lunch. A random resident reached over to Resident #4's lunch grabbing a food item from her plate. Resident #4 got up from the table yelled, grabbed the food back and gave a slap to the resident's left upper arm. On 1/10/07 at 9:15 a.m., the house manager stated that Resident #4 had been violent with residents and caregivers by becoming physically agressive. She made racial slurs towards caregivers. She further stated they may have to give the resident a 30-day discharge notice if the resident's behaviors did not change. On 1/11/07 at 5:00 p.m., the administrator confirmed the facility had not developed or implemented a BMP. Further, she stated the resident had a change in status as she had just recently exhibited inappropriate behaviors. On 1/11/07 at 5:05 p.m., the house manager confirmed the facility had not developed or implemented a BMP. The facility did not develop an NSA to include BMP's which included all situations that triggered Residents #3 and #4's inappropriate behaviors and failed to provide guidance to personnel in their provision of care and services to meet the needs of residents. III. Supervision 1. Review of Resident #2's record on 1/10/07 revealed the resident was admitted on 07/29/04	R 008		

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R 008	Continued From page 15 with diagnoses that included alcoholism, Parkinson's disease, dementia and psychosis. The resident's record contained a UAI dated 9/20/06 which documented the resident was frequently disoriented to person, place, time or situation and required supervision to light cigarettes appropriately or safely. The resident's record contained an NSA dated 9/20/06 which documented the resident was cognitively impaired and disoriented to person, place, time or situation. It also documented Resident #2's behaviors included lighting up cigarettes in the building. Additionally, the NSA documented cigarettes were to be stored in the medication closet. On 1/10/07 at 9:25 a.m., two lighters were observed lying on top of an end table in Resident #2's room. The house manager stated, "the resident is not supposed to have these" and she was observed picking up the lighters and placing them in the end table drawer. On 1/10/07 at 3:30 p.m., the resident was observed to ask staff to open the outside door to the smoking area. Once outside, the resident was observed to remove cigarettes and a lighter from his jacket pocket. Staff were not observed to check on the resident between 3:30 p.m. and 3:40 p.m. On 1/10/07 at 3:15 p.m., a caregiver stated the resident was allowed to smoke independently. She also stated that unopened packs of cigarettes were stored in the medication closet and the resident was allowed to keep an open cigarette pack and a lighter.	R 008		

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R 008	Continued From page 16 On 1/1/0/07 at 3:45 p.m., the facility nurse stated she had concerns about Resident #2's smoking without supervision. The facility failed to provide sufficient supervision to assure Resident #2's health and safety was protected at all times by not monitoring the use of his cigarettes and lighters. The facility failed to protect resident rights by not providing a safe and sanitary environment and failed to treat residents with dignity and respect for Residents #1, #2, #3, #4. This had the potential to affect 100% of the residents in the facility. The facility failed to develop an NSA to describe Resident #3's personal hygiene, nutrition and hydration needs. The facility failed to implement an NSA for Resident #1's personal hygiene care. The facility also failed to develop NSA's to include BMP's, which would provide guidance to personnel in their provision of care and services to meet the behavior management needs of Residents' #3 and #4. Additionally, the facility failed to provide supervision for Resident #2 by monitoring his cigarette and lighter use. These failures resulted in inadequate care.	R 008		

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Rosetta, Pendlebury	875 South Pendlebury	208-785-3627
Administrator	**City**	**ZIP Code**
Michelle Anderson	Blackfoot	83221
Survey Team Leader	**Survey Type**	**Survey Date**
Karen McDannel	Standard	1/12/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	161.03.c	Facility did not supervise Resident #2 who has a diagnosis of dementia and is on psychotropic medications while he smoked.		
2	161.03.d	The facility allowed smoking in an area where there were combustible materials including: pile of dried leaves, wooden fence and barbeque.		
3	161.03.e	The facility allowed smoking outside of designated area which was not at least 25 feet away from an entrance and/or exit.		
4	210	The facility did not engage residents in activities that promoted their individual needs. 3 of 4 sampled residents were not engaged in activities during the survey.		
5	250.14	The facility did not ensure the exterior secured environment was maintained. i.e: On 1/10/07 @ 9:32 AM on the initial tour the gate was found (Continued)		

Response Required Date	Signature of Facility Representative	Date Signed
2/12/07	Michelle Anderson	1-12-07

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Survey Team Leader	**Survey Type**	**Survey Date**
Karen McDannel	Standard	1/12/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
5	250.14	(Cont.) unlocked and again @ 4:57 PM the gate was observed unlocked.		
6	305.05	The facility RN did not follow-up or review the progress of a pressure ulcer for Resident #1.		
7	310.04.c	The facility did not monitor Residents #2 & 3's demonstrated behaviors in order to determine continued need for medication.		
8	310.04.d	The facility did not have a system in place to monitor the side effects of psychotropic medications that could impact residents health and safety.		
9	320.03	Resident #4 did not sign and/or date her NSA upon its completion.		
10	405.05.b	The facility did not ensure sidewalks are maintained and free of snow and ice build-up.		
11	450	The facility did not ensure tube steaks was not cooked in a timely manner.		

Response Required Date	Signature of Facility Representative	Date Signed
2/12/07	Michelle Anderson	1/12/07

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Karen McDaniel	Standard	1/12/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
12	600.06.b	A staff member worked alone without CPR and first aid Training. A second staff member worked alone without first aid Training.		
13	630.01	R One of three ~~personnel~~ personnel records reviewed revealed no dementia specialized training.		
14	630.02	1 of 3 personnel records reviewed revealed No mental illness specialized training.		
15	710.04	Facility did not obtain a History and Physical for Resident #3 within 6 months prior to admission.		
16	711.08.e	The facility did not notify the RN of Residents #3's "skin assessment" which identified dry, flaky and scratched areas on residents legs and feet.		
17	730.01.g	2 of 3 personnel records reviewed revealed there was no Criminal history clearance completed.		
18	300.02	Random Resident #5 had order for Blood glucose (Cont.)		

Response Required Date	Signature of Facility Representative	Date Signed
2/12/07	Michelle Anderson	1-12-07

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Karen McDaniel	Standard	1/12/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
18	300.02	(Cont.) checks 4 x's a day. The facility RN did not provide staff with instructions for what to do when fsbs blood sugars are too high or too low.		
19	625.03.d	2 of 3 staff members were not provided with job related orientation including: providing assistance with activities of daily living i.e.: staff members were observed conducting an inappropriate transfer of a non Resident #6.		

Response Required Date	Signature of Facility Representative	Date Signed
2/12/07	Michelle Anderson	1.12.07